MAIN STREET MEDICAL SERVICES PLLC
GASTROENTEROLOGY

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Your Name: _____ Date: _____

1. What is the reason for your visit today?
   _____
2. Who is your referring physician?
   _____
3. Do you have any medical conditions? YES or NO (if yes please list)

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

4. Have you ever had any surgeries in the past? YES or NO (if yes please list)

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

5. Do you take any medications? YES or NO (if yes please list)

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

6. Are you **allergic** to any medications? YES or NO (if yes please list)
   _____
7. Do you smoke? YES or NO
   A. If you answered Yes how much do you smoke?_____
8. Do you drink alcoholic beverages? YES or NO
   A. If you answered Yes how often do you drink?_____
9. Do you have any family history for any illnesses? YES or NO (if yes please list)

1) _____ 2) _____

10. Do you have any family history of cancer? YES or NO (if yes please list)

1) _____ 2) _____

11. Have you ever had a colonoscopy? YES or NO
    A. If you answered Yes when was your last colonoscopy and what were the findings at that time?_____
12. Have you had a complete blood test in the past year? YES or NO
13. If you were born during **1945-1965**, have you ever been tested for Hepatitis C?
    YES or NO